Figure SC810.F8. Form CA-2, "Notice of Occupational Disease and Claim for Compensation

Notice of Occupational Disease and Claim for Compensation

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Employee: Please complete all boxes 1 - 18 below. Do not complete shaded areas.
Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.

Employee Data

1. Name of employee (Last, First, Middle): BROWN, Myron I.
2. Social Security Number: 300-10-2222
3. Date of birth (Mo. Day Yr.): 3 18 40
4. Sex: M
5. Home telephone: (111)555-4444
6. Grade as of date of last exposure: Level WG-10 Step 5
7. Employee's home mailing address (include city, state, and ZIP code):
   1234 Elm Street
   San Antonio, TX 78253
8. Dependents
   - [X] Wife, Husband
   - [ ] Children under 18 y
   - [ ] Other

Claim Information

9. Employee's occupation: Utility Systems Repairer
   a. Occupation code: WG-4742
10. Location (address) where you worked when disease or illness occurred (include city, state, and ZIP code):
    CEAF
    Lackland AFB, TX 78236-5554
11. Date you first became aware of disease or illness (Mo. Day Yr.): 3 10 95
12. Date you first realized the disease or illness was caused or aggravated by your employment (Mo. Day Yr.): 3 10 95
13. Explain the relationship to your employment, and why you came to this realization:
    May last hearing examination showed I had a significant loss of hearing in both ears. I am exposed to noisy equipment most of the day, five days a week. I have been exposed to this noise for 15 years. I think this caused my loss of hearing.
14. Nature of disease or illness: Hearing Loss - both ears
    OWCP Use - NOI Code
    b. Type code: 700
    c. Source code: 0240
15. If this notice and claim was not filed with the employing agency within 30 days after date shown above in item #12, explain the reason for th delay.
    N/A
16. If the statement requested in item 1 of the attached instructions is not submitted with this form, explain reason for delay.
    N/A - Statement is Attached
17. If the medical reports requested in item 2 of attached instructions are not submitted with this form, explain reason for delay.
    N/A - Medical reports are attached.

Employee Signature

18. I certify, under penalty of law, that the disease or illness described above was the result of my employment with the United States Government, and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and other benefits provided by the Federal Employees' Compensation Act.

I hereby authorize any physician or hospital (or any other person, institution, corporation, or government agency) to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs (or to its official representative). This authorization also permits any official representative of the Office to examine and to copy any records concerning me.

Signature of employee or person acting on his/her behalf Myron I. Brown Date 3-18-95

Have your supervisor complete the receipt attached to this form and return it to you for your records.

Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensatic as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative rem as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

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Disability Benefits for Employees under the Federal Employees' Compensation Act (FECA)

The FECA, which is administered by the Office of Workers' Compensation Programs (OWCP), provides the following general benefits for employment-related occupational disease or illness:

(1) Full medical care from either Federal medical officers and hospitals, or private hospitals or physicians of the employee's choice.

(2) Payment of compensation for total or partial wage loss.

(3) Payment of compensation for permanent impairment of certain organs, members, or functions of the body (such as loss or loss of use of an arm or kidney, loss of vision, etc.), or for serious disfigurement of the head, face, or neck.

(4) Vocational rehabilitation and related services where necessary.

The first three days in a non-pay status are waiting days, and no compensation is paid for these days unless the period of disability exceeds 14 calendar days, or the employee has suffered a permanent disability. Compensation for total disability is generally paid at the rate of 2/3 of an employee's salary if there are no dependents, or 3/4 of salary if there are one or more dependents.

If an employee is in doubt about compensation benefits, the OWCP District Office servicing the employing agency should be contacted. (Obtain the address from your employing agency.)

For additional information, review the regulations governing the administration of the FECA (Code of Federal Regulations, Title 20, Chapter 1) or Chapter 810 of the Office of Personnel Management's Federal Personnel Manual.

Privacy Act

In accordance with the Privacy Act of 1974 (Public Law No. 93-579, 5 U.S.C. 552a) and the Computer Matching and Privacy Protection Act of 198 (Public Law No. 100-503), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended (5 U.S.C. 8101, et seq.) i administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor. In accordance with this responsibility, th Office receives and maintains personal information on claimants and their immediate families. (2) The information will be used to determin eligibility for and the amount of benefits payable under the Act. (3) The information collected by this form and other information collected i relation to your compensation claim may be verified through computer matches. (4) The information may be given to Federal, State, and loca agencies for law enforcement and for other lawful purposes in accordance with routine uses published by the Department of Labor in the Federa Register. (5) Failure to furnish all requested information may delay the process, or result in an unfavorable decision or a reduced level of benefits (Disclosure of a social security number (SSN) is voluntary; the failure to disclose such number will not result in the denial of any right, benefit o privilege to which an individual may be entitled. Your SSN may be used to request information about you from employers and others who knov you, but only as allowed by law or Presidential directive. The information collected by using your SSN may be used for studies, statistics, anc computer matching to benefit and payment files.)

Receipt of Notice of Occupational Disease or Illness

This acknowledges receipt of notice of disease or illness sustained by:
(Name of injured employee)

BROWN, Myron I.

I was first notified about this condition on (Mo., Day, Yr.)

March 18, 1995

At (Location)

CEAF

Lackland AFB, TX 78236-5554

Signature of Official Superior	Title	Date (Mo., Day, Yr.)
John C. Mills		March 22, 1995

This receipt should be retained by the employee as a record that notice was filed.

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NSTRUCTIONS FOR COMPLETING FORM CA-2

Complete all items on your section of the form. If additional space is required to explain or clarify any point, attach a supplemental statement o the form. In addition to the information requested on the form, both the employee and the supervisor are required to submit additional vidence as described below. If this evidence is not submitted along with the form, the responsible party should explain the reason for the elay and state when the additional evidence will be submitted.

Employee (or person acting on the employee's behalf)

Complete items 1 through 18 and submit the form to the employee's supervisor along with the statement and medical reports described below. Be sure to obtain the Receipt of Notice of Disease or Illness completed by the supervisor at the time the form is submitted.

1) Employee's statement

In a separate narrative statement attached to the form, the employee must submit the following information:

a) A detailed history of the disease or illness from the date it started.

b) Complete details of the conditions of employment which are believed to be responsible for the disease or illness.

c) A description of specific exposures to substances or stressful conditions causing the disease or illness, including locations where exposure or stress occurred, as well as the number of hours per day and days per week of such exposure or stress.

d) Identification of the part of the body affected. (If disability is due to a heart condition, give complete details of all activities for one week prior to the attack with particular attention to the final 24 hours of such period.)

e) A statement as to whether the employee ever suffered a similar condition. If so, provide full details of onset, history, and medical care received, along with names and addresses of physicians rendering treatment.

2) Medical report

a) Dates of examination or treatment.

b) History given to the physician by the employee.

c) Dealled description of the physician's findings.

d) Results of x-rays, laboratory tests, etc.

e) Diagnosis.

f) Clinical course of treatment.

g) Physician's opinion as to whether the disease or illness was caused or aggravated by the employment, along with an explanation of the basis for this opinion. (Medical reports that do not explain the basis for the physician's opinion are given very little weight in adjudicating the claim.)

3) Wage loss

If you have lost wages or used leave for this illness, Form CA-7 should also be submitted.

Supervisor (or appropriate official in the employing agency)

At the time the form is received, complete the Receipt of Notice of Disease or Illness and give it to the employee. In addition to completing items 19 through 34, the supervisor is responsible for filling in the proper codes in shaded boxes a, b, and c on the front of the form. If medical expense or lost time is incurred or expected, the completed form must be sent to OWCP within ten working days after it is received. In a separate narrative statement attached to the form, the supervisor must:

a) Describe in detail the work performed by the employee. Identify fumes, chemicals, or other irritants or situations that the employee was exposed to which allegedly caused the condition. State the nature, extent, and duration of the exposure, including hours per days and days per week, requested above.

b) Attach copies of all medical reports (including x-ray reports and laboratory data) on file for the employee.

c) Attach a record of the employee's absence from work caused by any similar disease or illness. Have the employee state the reason for each absence.

d) Attach statements from each co-worker who has first-hand knowledge about the employee's condition and its cause. (The co-workers should state how such knowledge was obtained.)

e) Review and comment on the accuracy of the employee's statement requested above.

The supervisor should also submit any other information or evidence pertinent to the merits of this claim.

Item Explanations: Some of the items on the form which may require further clarification are explained below:

14. Nature of the disease or illness
Give a complete description of the disease or illness. Specify the left or right side if applicable (e.g., rash on left leg; carpal tunnel syndrome, right wrist).

19. Agency name and address of reporting office
The name and address of the office to which correspondence from OWCP should be sent (if applicable, the address of the personnel or compensation office).

20. Employee's duty station, street address and ZIP code
The street address and zip code of the establishment where the employee actually works.

23. Name and address of physician first providing medical care
The name and address of the physician who first provided medical care for this injury. If initial care was given by a nurse or other health professional (not a physician) in the employing agency's health unit or clinic, indicate this on a separate sheet of paper.

24. First date medical care received
The date of the first visit to the physician listed in item 23.

32. Was the injury caused by third party?
A third party is an individual or organization (other than the injured employee or the Federal government) who is liable for the disease. For instance, manufacturer of a chemical to which an employee was exposed might be considered a third party if improper instructions were given by the manufacturer for use of the chemical.

Employing Agency - Required Codes

Box a (Occupational Code), Box b, (Type Code), Box c (Source Code), OSHA Site Code
The Occupational Safety and Health Administration (OSHA) requires all employing agencies to complete these items when reporting an injury. The proper codes may be found in OSHA Booklet 2014, Record Keeping and Reporting Guidelines.

OWCP Agency Code
This is a four digit (or four digit two letter) code used by OWCP to identify the employing agency. The proper code may be obtained from your personnel or compensation office, or by contacting OWCP.

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. . . . . Report of Occupational Disease. Please complete information requested below

upervisor's Report

'. Agency name and address of reporting office (include city, state, and ZIP Code)
394 MSSQ/MSCE
1821 Wilbur Wright Plaza
Lackland AFB, TX 78236-5554
ZIP Code

OWCP Agency Code: 1000-ZZ
OSHA Site Code:

). Employee's duty station (Street address and ZIP Code)
Same As Item 19
ZIP Code

. Regular work hours From: 7:30 ☒ a.m. ☐ p.m. To: 4:00 ☐ a.m. ☒ p.m.

22. Regular work schedule ☐ Sun. ☒ Mon. ☒ Tues. ☒ Wed. ☒ Thurs. ☒ Fri. ☐ Sat.

. Name and address of physician first providing medical care (include city, state, ZIP code)
A. B. Simpson, MD
4000 Oak Street
San Antonio, TX 78236

24. First date medical care received: Mo. 3 Day 10 Yr. 95

25. Do medical reports show employee is disabled for work? ☐ Yes ☒ No

. Date employee first reported condition to supervisor: Mo. 3 Day 18 Yr. 95

27. Date and hour employee stopped work: Mo. N/A Day Yr. Time : ☐ a.m. ☐ p.m.

. Date and hour employee's pay stopped: Mo. N/A Day Yr. Time : ☐ a.m. ☐ p.m.

29. Date employee was last exposed to conditions alleged to have caused disease or illness: Mo. Day Yr. Continues in same duties and cautioned to wear protection devices over ears.

. Date returned to work: Mo. Day Yr. Time : ☐ a.m. ☐ p.m.

. If employee has returned to work and work assignment has changed, describe new duties

Work assignment has not changed.

. Was injury caused by third party? ☐ Yes ☒ No If "No," go to Item 34.

33. Name and address of third party (include city, state, and ZIP code)

gnature of Supervisor

. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect to this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

John C. Mills
me of Supervisor (Type or Print)

John C. Mills
nature of Supervisor

March 25, 1995
Date

Chief, AC Section
ervisor's Title

(111) 555-6666
Office phone

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